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The role of the state in the social inclusion of complementary and alternative medical occupations

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Summary

Objective: To examine the views of government spokespersons regarding the efforts of five complementary and alternative medicine (CAM) groups (chiropractic, traditional Chinese medicine/acupuncture, naturopathy, homeopathy and Reiki) to take their place in the formal health care system.
Design: In this small scale, exploratory study, we conducted in-depth interviews with 10 key government officials at the federal (5), provincial (4) and municipal (1) levels. We used qualitative techniques such as constant comparison to describe and explain their responses to three main questions: (1) What should be the role of the state in the professionalization of CAM? (2) Is there a legitimate place for CAM groups in the formal health care system? and (3) Should CAM services be integrated with conventional medical care?
Setting: Ontario, Canada.
Results: The findings identify a fundamental tension between the various levels of government. Their mandate to protect the public comes into conflict with the obligation to respond to consumer pressure for CAM. Safety, efficacy and cost-containment were the chief explanations given for the government's slowness to catch up to consumers. They also mentioned fears of rising health care costs and the lack of cohesion among and between CAM groups as barriers to legitimacy and integration.
Conclusion: Realizing the professional aspirations of CAM practitioners will depend on the outcome of a political contest between the public, the state and the established health care professions.

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Introduction

Complementary and alternative medicine (CAM) occupations are currently working towards inclusion into mainstream medicine. In the late nineteenth century, groups such as midwives, herbalists, and homeopaths were able to practice alongside physicians without licensing by the state.[1] With the growth of medical schools based on biomedical scientific models and the diffusion of new technologies and diagnostic tools, occupations that were once socially included became marginalized.[2,3] When the American and Canadian Medical Associations assumed powerful roles after the turn of the century, the medical profession gained state support and exerted their influence to exclude the more poorly organized eclectic healers. What we are seeing today is a concerted effort by a number of CAM occupations to win back their legitimate right to practice, through the mechanism of state-sanctioned regulation. In this paper, we examine the role of the state in this struggle with an emphasis on the regulators. This is a small scale, exploratory study located in the Province of Ontario (Canada). It is based on the views of leading government officials at the federal, provincial and municipal levels.

Professions and the state

To study the professions leads us inevitably to an examination of the close links between professional bodies and the state. Klein describes the relations between the professions and the state as a symbiotic relationship, which he calls "the politics of the double bed".[4] Macdonald argues that all professions have to enter into a special relationship, or 'a regulative bargain' with the state. He contends that professions have arrived at their current position through struggle and negotiation with the state as well as within and between their own organizations and with other groups.[5] Indeed, Macdonald argues that state control is not only necessary for the professions; it constitutes part of their legitimacy and power. Certainly, negotiations with the state are a means by which professions can seek to regulate market conditions to their advantage against competitors and enhance their own privilege and status through social closure.[6]

Light regards the state as a countervailing power.[7] This concept builds on the work of Johnson and Larsen and focuses attention on the interactions of powerful actors like the professions and the state, which have their own interests and agendas.[8,9] Light sees them as inherently interdependent yet distinct. If one party is dominant, as in the case of the medical profession, its dominance will eventually elicit counter-moves by other powerful actors such as the state, in order to redress the balance of power. Each party has legitimate goals and values that do not fit easily with the others. Light argues that in pursuing its own interests, the state will seek to either facilitate or constrain the extent to which a profession is able to fulfill its roles and objectives.[7] Coburn et al. emphasize that when we examine the professions and their relationship with the state, we cannot adequately analyse them in isolation from the social context within which they are embedded.[10] The broader societal structures and trends that exist at a given time shape the nature of professional developments and strongly influence the ways that the state responds to these developments. In our current knowledge-based and service-oriented society, state regulation and protection of qualification have become increasingly important considerations for the professions.

The health professions and the state

The link between the state and the health professions is strong because a key responsibility of the state is to protect the health and welfare of its citizens. Governments must pose questions such as "Does it do harm?" and "Does it do good"? The state seeks credible evidence to answer these questions as a basis for devising health care policy although political considerations sometimes take precedence. This responsibility of the state is closely linked these days to concerns of governments throughout the developed world to rationalize health care and obtain enhanced value for the public funds they spend. As well, in order to maintain its legitimacy, the state needs to respond to the growing public demand for increased choice of health care modalities.

In the search for professional legitimacy, regulation or licensure by the state is a key factor.[11–13] The health professions have historically sought to secure statutory regulation and thereby achieve social closure and market control.[5,9] This step involves erecting a boundary around a health profession's expert knowledge and creating a monopoly through credentialism and certification, which excludes outsiders.[14] The medical profession has been eminently successful in establishing a position of dominance with monopolistic powers accorded to physicians and endorsed by the state. Medicine has been able to achieve control over the content of care, over patients, over other types of health care

practitioners and over the context within which care is provided.[15] Today, however, we are seeing the gradual erosion of medical power. In various societies, scholars have demonstrated that medicine is not as dominant as it was 30 or 40 years ago, and its superior status is being questioned.[10,16–18] The traditional boundaries in the division of labour are being challenged as new health care professions emerge. Other occupations and professions such as midwives and nurse practitioners have made gains, sometimes at medicine's expense.[19] Complementary and alternative medicine occupations have won acceptance from large segments of the public and are placing pressure on medicine's former hegemony in the health care system.[42,28]

Complementary and alternative medicine and the state

Until recently, the state has had little interest in CAM groups. Practitioners were regarded as 'irregular healers' who operated outside the formal health care system.[20–22] The recent thrust of several CAM groups to move from the margins into the mainstream has changed the picture and resulted in their increasing involvement with various levels of the state.[13,14,20]

This pattern is evident in a number of developed countries. Scholars such as Dew in New Zealand, Carlton and Bensoussan and Willis and White in Australia, Saks in Britain, Schepers and Hermans in the Netherlands, and Goldstein in the United States have analyzed the extension of regulation by the state for selected CAM groups such as chiropractors and traditional Chinese medicine doctors.[12,22–26] A recurring theme among their findings is that regulation has led to increasing standardization of CAM practices and philosophies. Furthermore, as randomized controlled trials (the gold standard for demonstrating efficacy of health care treatment) have infiltrated the research model, the medical profession has used this tool to insist that CAM groups produce 'scientific evidence' of the efficacy and safety of their practices.

Several CAM groups are currently striving to move from occupational status to becoming full professions.[22,27,28] In order to gain legitimacy within the health care system, they are seeking statutory self-regulation, one of the crucial steps required for full social inclusion. In making their case for self-regulation, these groups are developing many of the traits typically associated with being a profession.[29] Nevertheless, they have been hampered in their efforts to achieve legitimacy by the general absence of state support.[30]

In the Province of Ontario, two formerly marginal groups have succeeded in joining the ranks of the self-regulated health care professions; chiropractors and midwives. They achieved this status largely as a result of political lobbying, organizational cohesion and popular demand.[31,32] Professional recognition by the state came in the form of regulatory status and inclusion in the province's health care insurance scheme, despite opposition from the medical establishment.

Related to the attempts of CAM groups to achieve legitimacy, is the issue of integration. As the public demand for CAM has grown and established health care providers have begun to take an interest in CAM therapies and products, serious consideration is being accorded to the prospect of 'integrative care'.[33] While there is little consensus concerning how an integrated system of health care should be operationalized, the basic principle is the use of non-hierarchical interdisciplinary teams that blend the best of both conventional medicine and CAM.[34–36] The goal is to bring together different approaches to create a new whole.[37] Such a development would herald a transformation of professionalism, permitting access to new actors and the pluralization of expert knowledge.[38]

In seeking to move into the mainstream, aspiring health occupations have found it advantageous to solicit direct state support.[19,39] Governments are currently turning their attention to CAM and are seeking to assess the validity of their claims. Issues such as efficacy, safety and cost-effectiveness, regulation of practitioners, the granting of legitimate professional status, and the integration of CAM into the health care system are under careful scrutiny by the state.

CAM and the government of Ontario

When we speak of health care and the state in Canada, we must recognize that there are three distinct levels of government involved. Health care is basically a provincial responsibility; constitutional jurisdiction over health care policy is clearly lodged at the provincial level and it is the provinces that foot most of the bills.[1,40] It is the federal government, however, that determines the overall context for the priorities that provincial governments need

[1] The federal share of funding for health care is currently under 20% (Ibbitson).[54]

to address.[2] Municipal governments have their own specific responsibilities at the local level. While taking into account the particular perspectives of the three levels of government, this research focuses primarily on the relationship between CAM groups and the government of the province of Ontario.

Recently, the state has adopted a more open, less monopolistic model for the governance of self-regulated health professions; a model which departs from a purely medical version of health care and allows other kinds of groups to seek regulation.[13] The central premise of the new approach is "that the sole purpose of professional regulation is to advance and protect the public interest" (HPLR).[41] With that goal in mind, the government devised nine criteria which a group must meet if they wish to achieve statutory self-regulation.[3] Underlying this move were a number of key questions (HPLR).[41] The first concern was jurisdictional . . . should the provincial Ministry of Health assume responsibility for regulating the profession? The second question examined whether statutory regulation of the profession was necessary—i.e. is there a "significant risk of harm to the patients" in what members of the group do, and are existing control mechanisms (e.g. monitoring, supervision, other forms of regulation) insufficient? Third, would regulation of any kind be feasible—is there a body of knowledge that could form the basis for the profession's standard of practice, and is appropriate Canadian post-secondary training available? The final question considered whether professional regulation was practical to implement—are there sufficient members, and are they able to favour the public interest over professional self-interest? This new model of self-regulation came into existence under the Regulated Health Professions Act of 1991. It is this regulatory structure that CAM groups in Ontario must satisfy when they seek to achieve full professional status.

Previous scholarly work has shown that while some emerging health professions have been able to gain official recognition within the health care system in Ontario during the last two decades, this legitimization has entailed important costs.[19,42] Recognition by the state has often required reduction or modification of the profession's original goals or modes of practice, medicalization of their approach, or acceptance of a limited or subordinate role in the system of health care.[43,12] This is a risk that aspiring CAM occupations groups need to take into account as they negotiate with the state about fitting into the existing system.[16,19,31]

It is important to recognize that the efforts of CAM groups to professionalize are occurring at a time of major economic and political upheaval and restructuring in the health care system. In Ontario, where there has been a long-standing pattern of accommodation between the state and the medical profession, the government has recently been playing an increasing role in managing the health care system and the health care division of labour.[42,44,45] Since the late 1960s, when a publicly funded medical insurance system was initiated, there has been a gradual growth of administrative supervision of the health care professions by the government and the gradual imposition of managerial power over the form and content of professional work. This period has been characterized by the development of new methods of regulating health care practitioners, a change in the defined roles of health care providers, and an expansion in the number of regulated health professions (e.g. chiropractic and midwifery). These changes have resulted in a redistribution of power among health care professionals as well as a transfer of some professional power to health care managers and the state.[44]

Our research examined the relationship between the state and aspiring CAM groups within this social and economic context. Different levels of government have different mandates and powers, which significantly affect their views and their abilities to shape policy and influence the nature of health care. Here we examine their individual perspectives allowing for their particular place in the structure of government and the constraints this imposes. Our focus is on the extent to which government health care officials are sympathetic to the public demand for CAM and the current efforts of complementary and alternative practitioners to professionalize. Our data address their views on three main questions: (1) What should be the role of the state in the professionalization of CAM? (2) Is there a legitimate place for CAM groups in the formal health care system? and (3) Should CAM services be integrated with conventional medical care?

[2] Recently, the federal government of Canada has assumed responsibility for regulating natural health products (NHP). They were able to do this because the legislation permitted it and NHPs fell under their jurisdiction.

[3] The nine criteria for statutory self-regulation as identified by HPLR and later adopted by HPRAC are: (1) relevance of the proposed self-regulating group to the Ministry of Health, (2) risk of harm to the public, (3) sufficiency of supervision, (4) alternative regulatory mechanisms, (5) body of knowledge, (6) education requirements for entry to practice, (7) ability to favour public interest, (8) likelihood of compliance and (9) sufficiency of membership size and willingness to contribute (HPLR,[41] HPRAC[50]).

Methods

The data for this study were derived from in-depth personal interviews with ten government spokespersons who had knowledge of, and some responsibility for policies concerning CAM. While our sample was small, it did consist of the relevant officials in the health departments at the federal (5), provincial (4) and municipal (1) levels. In this paper, we identify respondents according to the level of government they represent (F = federal, P = provincial and M = municipal). Everyone we approached for an interview agreed, with the exception of one prominent member of the provincial government who never replied to our requests. All interviews were audiotape and transcribed.

Our questions were derived from the sociological literature on professions and also from our previous research with leaders of the five CAM groups.[4,5–8,14,28,53] While the questions covered the core areas of our interests, respondents were encouraged to add their own comments and opinions.

In hour-long semi-structured interviews, we asked whether these government representatives thought that any or all of the following five CAM groups: chiropractic, naturopathy, acupuncture/traditional Chinese medicine, homeopathy and Reiki, should be included in the formal health care system (respondents were given a card listing the names of the five CAM groups to assist their thinking). If they did not believe these groups belonged in the system, we asked what they would have to do to be included. We also inquired about perceived barriers and opportunities for gaining a legitimate place in the system, as well as how they perceived the role of the state in the professionalization process, and their views on future prospects for integration of complementary and alternative health care with conventional medicine.

We used the software program NVivo to analyse the responses of the government stakeholders.[46] Each transcript was coded independently by four investigators using constant comparison analysis.[47] The central codes that emerged from the interviews were based on the key concerns and perceptions of the respondents. We extracted constructs and concepts from replies to open and closed-ended questions and spontaneous comments, and examined them for similarities and differences. To further organize the data, we then identified underlying themes and categories such as an appropriate role for the state, legitimation and integration.[48,49] Sandelowski has described this form of analysis as especially amenable for answers to questions of relevance to practitioners and policy makers.[47] Since this is an exploratory study with a small sample, we refrain from making generalizations with scientific authority. We can, however, describe and explain how these health care officials perceive the challenge of CAM occupations attempting to move into mainstream health care.

[4] These five groups were originally selected for study because they represented a spectrum of legititmacy and are currently at different points in the process of winning self-regulatory status.

Findings

In their responses to our three research questions, these representatives of the state brought to our attention a number of recurring themes: (1) consumer pressure for CAM services, (2) protecting the Canadian public, (3) lack of scientific evidence for efficacy and safety, (4) limitations of authority, (5) controlling health care costs, (6) maintaining professional boundaries, (7) evolution of the health care system, and (8) lack of cohesion among and between CAM groups. It is worth noting that most respondents were familiar with chiropractic, traditional Chinese medicine/acupuncture and naturopathy, while homeopathy and Reiki were relatively unknown to them. In effect then, these government officials were focusing their remarks on the more familiar three CAM groups.

Consumer pressure for CAM

All our government respondents were sensitive to the appeal of CAM to the public. They recognized that Canadians are looking to CAM practitioners to provide treatment, especially for chronic health problems and for preventive measures. They understood that consumers want to have a choice in the kind of care they can utilize, and seemed supportive of this demand. As one put it: "People want it. It has become an important part of the health of Canada and has achieved legitimacy in the market place. ... Their strongest advocates are their patients and the people who use them" (2F) It seems clear that the interest of the public in having multiple options for care is making the notion of social inclusion of CAM groups more salient to the state.

The government representatives in our sample recognized that they needed to respond in a practical way to consumer pressure for CAM services. As one commented: "There is huge public acceptance, so governments are usually playing catch up. It is an issue whose time has come and we need to recognize that in a formal way. The system as a whole needs to reflect the reality of peoples' lives. We

have to fit people's lives, as opposed to them fitting into the system" (2F). This same respondent acknowledged that professional legitimacy is principally a political decision, rather than one based solely on scientific evidence: "There is no question that these are ultimately political decisions. It is up to the citizens to ask these questions of their elected officials and those who are seeking office. ... The only way to get something done in government is to rally the people that are supportive of your case and hold your governments accountable"(2F). Other respondents such as this provincial civil servant affirmed this view: "The government has now seen the public interest; it has taken time for the interest to sink in, but now it is public demand that is driving the agenda" (4P).

Protecting the Canadian public

When asked what they believe the role of the state should be in responding to the growth of CAM, all these respondents emphasized that they are mindful of their mandate to protect the Canadian public: "I work for the people, and the public are my allies. We make policy in the public interest" (3F). Another stressed the fact that: "We are responsible for the safety of the consumers of health care" (6P). They regarded the granting of statutory self-regulation as a mechanism for ensuring the safety of the public and creating accountability among health care practitioners. They viewed self-regulation as a bargain between the state and the health profession; it confers legitimacy and consequent socio-economic status in exchange for constraints that protect the public interest.

Several argued that if CAM groups were to achieve statutory self-regulation, they would be more likely to gain social inclusion: "Canadians need to make sure that they have got legitimate professionals looking after them and regulation provides that ... some form of certification" (9F). A provincial respondent said: "We set standards for the health professions that are regulated. We look at safety, quality of care, efficacy and public interest. Our job is to ensure the public interest. Regulation means that everyone is working with the same rules" (6P).

Lack of scientific evidence for efficacy and safety

Most of the government people we interviewed said that they could foresee a legitimate place for CAM groups within the formal system of health care. It was their opinion, however, that it would be essential to ensure that CAM health care treatments are efficacious, safe, of good quality and meet broadly accepted standards of training and practice. In line with their belief that it is the government's responsibility to protect the health of its citizens, they saw it as necessary to require solid evidence that CAM will do no harm. This federal government official's response to our question is typical: "Yes, there is a place for them in the system. However, it is our job to make sure that there is evidence of effectiveness and safety, standards of training, credentialing, and effective control over practice. These groups need to be accountable for what they do" (8F).

Our respondents suggested that CAM practitioners would achieve better acceptance from conventional medicine as well as government if they were to generate scientific evidence for their therapies. One commented: "I strongly support an evidence-based approach. It would provide an appropriate opening for CAM to enter the system" (10F). Another pointed out that there may be a higher standard of evidence expected than has previously been demanded for conventional medicine: "It is unfortunate that these guys are being held to a higher standard than those who are already part of the established mainstream, but two wrongs don't make a right" (5M). The current requirements for evidence are not, however, solely related to CAM. In recent years there has been a widespread move to evidence-based medicine and the development of clinical guidelines for all forms of medical care.[52] One federal government spokesperson said he was aware that at this point in time, CAM does not have sufficient resources to fund the sophisticated kinds of research that can provide credible evidence of efficacy and safety. He argued that it was up to the government to provide funds to build research capacity among CAM practitioners so that they can do the research upon which such assessments may be made (9F).

Limitations to authority

Despite the fact that regulation is a responsibility of provincial governments, the picture differs from one province to the other. In Ontario, the chiropractors have already achieved self-regulation, but other CAM groups are still in the process of seeking to become regulated. The federal officials we spoke with emphasized that they had no authority to initiate any move toward regulation. As one said: "The federal government can only try to create the right climate; it is the responsibility of the provinces to move ahead with regulation. It is ultimately their decision" (2F). This respondent claimed that the

slow pace at which provincial governments have granted this status to CAM groups is due, at least in part, to the lack of scientific evidence of efficacy and safety: "Governments are not comfortable and there has to be a comfort level. The groups need to build up a body of evidence that it is safe. If they take the time and make research a priority, they can convince governments to respond to them" (2F). A provincial government official commented that it is the role of his government "to see if there is evidence of efficacy to protect the public" (4P). Another mentioned the need for educational standards for CAM practitioners: "They need in place a system of education that can stand up to scrutiny by other professions" (1P). These statements highlight the sense of responsibility for the health of the public felt by these government spokespersons as well as the limitations placed on the separate levels of government.

Controlling health care costs

Government officials explained that they hesitated to endorse the legitimation of CAM because they had serious concerns about the costs of health care. The spokespersons for the provincial government seemed to believe that the health care system is already under sufficient pressure without adding the burden of CAM to it. They feared that CAM groups would make demands for public funding that the government could not handle. As one phrased it: "If [by legitimacy] you mean funding from the provincial coffers, that is debatable ... I think that this will be a challenge in the future. Psychologically, they are legitimate, that is one thing, but I don't think that legitimacy should mean they are part of provincial funding" (4P). Another provincial spokesperson remarked "We are moving slowly on regulation because the government is not comfortable; there has to be a comfort level and costs are a big part of that" (1P). Since the funds come primarily from provincial coffers, concerns about escalating costs were expressed more frequently by provincial governments. As a federal representative put it: "It is their decision and they seem to feel that they don't need any more work or costs" (2F).

These respondents also saw the cost of health care as a barrier to integrating CAM into mainstream medicine. Their concern about integration was with its potential for increasing health care costs: "It is a challenge for the government with limited time and resources. There is nervousness about possible liability issues, and pressure from the medical community to invest more money into the medical side of things rather than CAM" (9F). Another said: "I blame the day to day pressure on the provincial health budgets. It is so difficult ... They know that there are solutions in the long-term, but in an eight-hour day, maybe seven and a half of that time is spent on the acute care issues that constantly dominate the health care system. They don't have time to deal with new ideas because they have to deal with crises. The mentality of crisis management is like a brick wall" (1P). The current efforts of government to curtail costs are clearly a barrier to policy decisions that could lead to integration of health care services.

Maintaining professional boundaries

These government officials were familiar with the extent of competing interests and jurisdictional disputes among the various health care professions, and believed that a clear and appropriate scope of practice was essential for any CAM group wishing to achieve a legitimate place in the system: "The various groups have to identify the definition of their profession and how it is similar and distinct from others to which it would relate. It is harder for them to squeeze in because it is musical chairs and ninety-nine percent of the chairs are taken" (5M). For example, the naturopaths have a very broad scope of practice that overlaps with a number of other specialties. Their scope of practice includes nutrition, acupuncture, diagnosis, herbal medicine, some chiropractic and homeopathy as well as lifestyle counseling.[50] This overlapping scope of practice makes it difficult to achieve social closure for their specialty and hampers efforts to make distinct jurisdictional claims.

Concerns about scope of practice also surface when it comes to the influence of the medical profession on governmental decisions. As this federal spokesperson explained: "The people who are on the other side of the fence would be the people that are in the standard medical treatment paradigm. They are not supportive because it steps on people's toes and it infringes on what they are doing right now" (3F). Another respondent saw serious opposition to the legitimacy of CAM practitioners coming from "the College of Physicians and Surgeons who are totally opposed to anybody infringing on their territory. It has nothing to do with the issue itself, it has to do with trying to protect your turf" (1P). As a municipal official said, "The barriers are with the established medical community. The battles that are going on are legion. They want tried and tested research on CAM first. This is not a criticism of them; they are honest in their convictions in that they respect only scientific evidence and not

anecdotal evidence" (5M). Another mentioned the education of physicians: "The training programs we have for doctors is part of the problem. We need to work on that through an initiative to include some awareness of CAM in the medical schools at the undergraduate level" (9F). Government officials perceived the lack of acceptance of CAM on the part of many members of the medical community as a critical obstacle to integration.

Evolution of the health care system

When thinking about how the health care system might evolve in the future, most of the government respondents were hesitant about the notion of integrating CAM care with conventional medical care as equal partners. A provincial civil servant predicted that this development would evolve sometime in the future: "It will be an evolution of the health care system." He based his view on the observation that: "The practitioners in the field have come to investigate and recognize the value in this. It is not something that the government has suggested or dictated" (6P).

While these government spokespersons were prepared to give serious consideration to the idea of integrating care, they acknowledged that it would not happen quickly or easily. As one commented: "It has to be thought out carefully before action is taken. ... Mainstream health care is not looking at these groups with open arms, in particular the practitioners working in particular areas like cancer and HIV or palliative care. The path is not as open as it would be for a conventional practitioner" (8F).

In connection with integration, several government officials referred to the desirability of primary care reform: "The models of care also have to change and we have to look at alternatives for all health care professionals. ... If more physicians were put on salary then they would be more than willing to be part of a team approach and team practices" (9F). They saw primary care reform as the starting point for the potential integration of health care services. A provincial spokesperson told us: "We are trying to redesign primary care, introducing things like group practices and alternative forms of funding. There is an opportunity there for CAM to find a place within a new system" (4P). The federal government respondents, however, again stressed that this would be a provincial responsibility: "What really matters is what the provinces think. ... It is ultimately their decision as to how various stakeholders are integrated into the formal health care system"(2F). In this matter, as with everything related to implementing health policy, the federal government must leave the concrete decision-making to the provinces.

Several government spokespersons qualified their approval of integrated care by arguing that it should be restricted to hospital settings: "I think there is a place for alternative practices in the hospital. If somebody wants to incorporate them into their hospital treatment then they can"(7P). Another respondent stated: "When it is within a structure or system it is a real opportunity to learn and share with others. There is a first hand relationship between doctors, nurses, and others and they can find a way of working out a protocol for referrals" (8F). The anxiety expressed by these respondents was that integrating CAM with conventional medicine could result in dangerous interactions between the two types of medications: "The concern about taking some of these treatments into the hospital is possible interactions" (3F). It seems that even if integration is restricted to hospitals, where the medical profession can oversee it, some government representatives are not completely comfortable with the idea.

Lack of cohesion among and between CAM groups

Some respondents explained the reluctance of government to include CAM in the formal health care system by referring to the lack of organization among the CAM groups. They said that they found it difficult to deal with fragmented occupations in which various sectors often express contradictory positions. They believed that these groups would have to become much more cohesive in order to work effectively with medicine and with government: "A problem is the controversy within the groups themselves. They are not the easiest groups to deal with and that is a challenge. ... They are not willing to work together and they argue and don't present their issues clearly. They need to work out a shared position. It requires cultural change" (9F). Another respondent made the same point: "They [the CAM groups] haven't focused their resources adequately and this makes it difficult to overcome political opponents at both the provincial and federal level" (4P). While a few CAM groups have managed to organize themselves effectively, most are still in the process of overcoming internal conflicts and tensions among their own members. Furthermore, the leaders of the different groups recognize that they are unable to coalesce and speak with one voice for CAM.[53] This lack of cohesion constitutes a significant obstruction to integrating CAM therapies into the overall system of health care.

Conclusion

Macdonald's contention that in order to professionalize, aspiring groups must struggle and negotiate within and between their own organizations explains some of the difficulties currently being experienced by CAM groups in their relationship with the state.[5] The lack of agreement and organizational cohesion among them and their inability to negotiate from a united position put them at a serious disadvantage when they attempt to advance their cause. Moreover, pressures on government from other more established health professionals, particularly physicians, hinder the legitimation and integration of CAM. Collins emphasizes that these other groups zealously protect their own professional interests.[6] In view of all these factors, the state continues to be wary of change and to move with caution.

The findings outlined here, while derived from a small scale, exploratory study, nevertheless point to a fundamental tension between the state's mandate to protect the public, and its obligation to respond to consumer demands for health care. The answers to our questions, while expressing some sympathy with the cause of CAM, nevertheless indicated hesitation and caution. In spite of our inability to generalize, we believe this study demonstrates that the state is in a difficult position to respond to claims from CAM organizations. It must take into account the concerns of other health professionals, as well as economic considerations and political constraints stemming from attempts to restructure the system. These government spokespersons explain their slowness to catch up to consumers by referring to concerns about the lack of scientific evidence of safety, efficacy and cost-containment. But does this not really constitute a "catch 22" situation for the CAM groups? The kind of research evidence that is being asked of them costs a great deal to conduct. Yet, they receive little financial support from governments to do the research. Similarly, high educational standards are being demanded of them, yet they receive no government funding for training their practitioners. None of the respondents expressed any awareness that concepts such as cost-effectiveness and efficacy are socially constructed notions that are subject to the influences of time, place and particular interests.[51]

Our data also show that the role of the state in legitimating CAM is complicated by the lack of integration between the various levels of government. The health care system in Canada has been described as a model of compromise that combines national standards and provincial experimentation.[40] Yet, the model does not always work effectively. The federal government respondents in our study were more favourably disposed to including CAM in the health care system than were the other levels of government, but their influence is limited by the fact that the provinces have the constitutional jurisdiction to regulate health care professionals, including CAM practitioners. The political and economic tensions between the various levels of government create a climate that makes change difficult to achieve. While all our respondents said that they favour social inclusion for CAM groups, the federal and municipal arms of government can only recommend, while provincial governments have been slow to grant statutory self-regulation to CAM groups. Without this key step in formal legitimation by the state, the process of social inclusion into the mainstream cannot proceed.

This tension between federal government policies and the willingness of provincial and municipal governments to institute measures that will reflect these policies is not restricted to the social inclusion of CAM. For many years, the federal government has urged that long-term care, home care and child care become priorities across the country. Yet, provincial governments have taken only minimal steps to realize these goals. Federal funding of the Canadian health care system does not include the ability to earmark budgets for specific needs. Thus, the provinces are free to establish their own priorities and to design their health care iniatives based on the way they decide to balance the demands of their constituents with their health care budgets. Their particular versions of the way the system should evolve frequently differ from the federal government's policies. As one of our respondents pointed out, provincial governments are in the position of having to manage health care in a crisis mode rather than operating from a comprehensive, long range plan of action. The CAM groups are caught between the vision of the federal government and the inability of provincial and municipal governments to execute that vision.

To move from the margins to the mainstream, the CAM occupations will need to have ongoing dialogue and negotiations with the state about issues such as cost-effectiveness, evidence-based care and the overall shape of health care in the future. Ultimately, as Light suggests, it will be a political contest between the countervailing powers of the professions, the public and the different levels of the state that will decide the fate of CAM groups' professional aspirations.[7]

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